

North Carolina's Certificate of Need Law in the 21st Century: A Practitioner's View

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Noah H. Huffstetler, III

Presented to the House Select Committee on Certificate of Need and Related
Hospital Issues

Nelson
Mullins

Nelson Mullins Riley & Scarborough LLP

Outline

- **Development of CON Law**
- **Changing Landscape of Healthcare**
- **Reasons to Retain CON Regulation**
- **Opportunities for CON Law Reform**

Development of CON Law

- **1966** **Congress enacts the Comprehensive Health Planning Act**

 Cost-based federal reimbursement for health care expenses
- **1971** **North Carolina General Assembly enacts a state CON law**
- **1973** **North Carolina Supreme Court struck down the law as unconstitutional**

We find no such reasonable relation between the denial of the right of a person, association or corporation to construct and operate upon his or its own property, with his or its own funds, an adequately staffed and equipped hospital and the promotion of the public health. Consequently, we hold that G.S. s 90-291 is a deprivation of liberty without due process of law, in violation of Article I, s 19 of the Constitution of North Carolina insofar as it denies Aston Park the right to construct and operate its proposed hospital except upon the issuance to it of a certificate of need

Such requirement establishes a monopoly in the existing hospitals contrary to the provisions of Article I, s 34 of the Constitution of North Carolina and is a grant to them of exclusive privileges forbidden by Article I, s 32.

**Supreme Court of North Carolina in the Matter of Certificate of Need for Aston Park Hospital, Inc.
Jan. 26, 1973
282 N.C. 542, 193 S.E.2d 729**

Development of CON Law

- **1977 North Carolina General Assembly again enacted a CON law**

The General Assembly of North Carolina makes the following findings:

...

(5) That a certificate of need law is required by Title XV of the Public Health Service Act as a condition for receipt of federal funds. If these funds were withdrawn the State of North Carolina would lose in excess of fifty-five million dollars (\$55,000,000).

N.C.G.S. 131-175 (5)

Development of CON Law

➤ **1986 Federal health planning law repealed**

It is also with great pleasure that I can finally lay to rest the Federal health planning authorities. I have sought their repeal since I assumed office. These authorities, while perhaps well-intentioned when they were enacted in the 1970's, have only served to insert the Federal Government into a process that is best reserved to the marketplace. Health planning has proved to be a process that was costly to the Federal Government, in the last analysis without benefit, and even detrimental to the rational allocation of economic resources for health care.

Development of CON Law

- **1993, 2001** **North Carolina's CON law made more restrictive**
- **2004** **Federal Trade Commission & Department of Justice recommend states consider abolishing CON programs**

Recommendation 2:

States should decrease barriers to entry into provider markets.

- a) States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs.**

The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market.

Federal Trade Commission and U.S. Department of Justice, July 2004

1970s versus 2011

The changing landscape of healthcare





**Cost-based reimbursement
superseded by prospective
payment ("DRGs")**

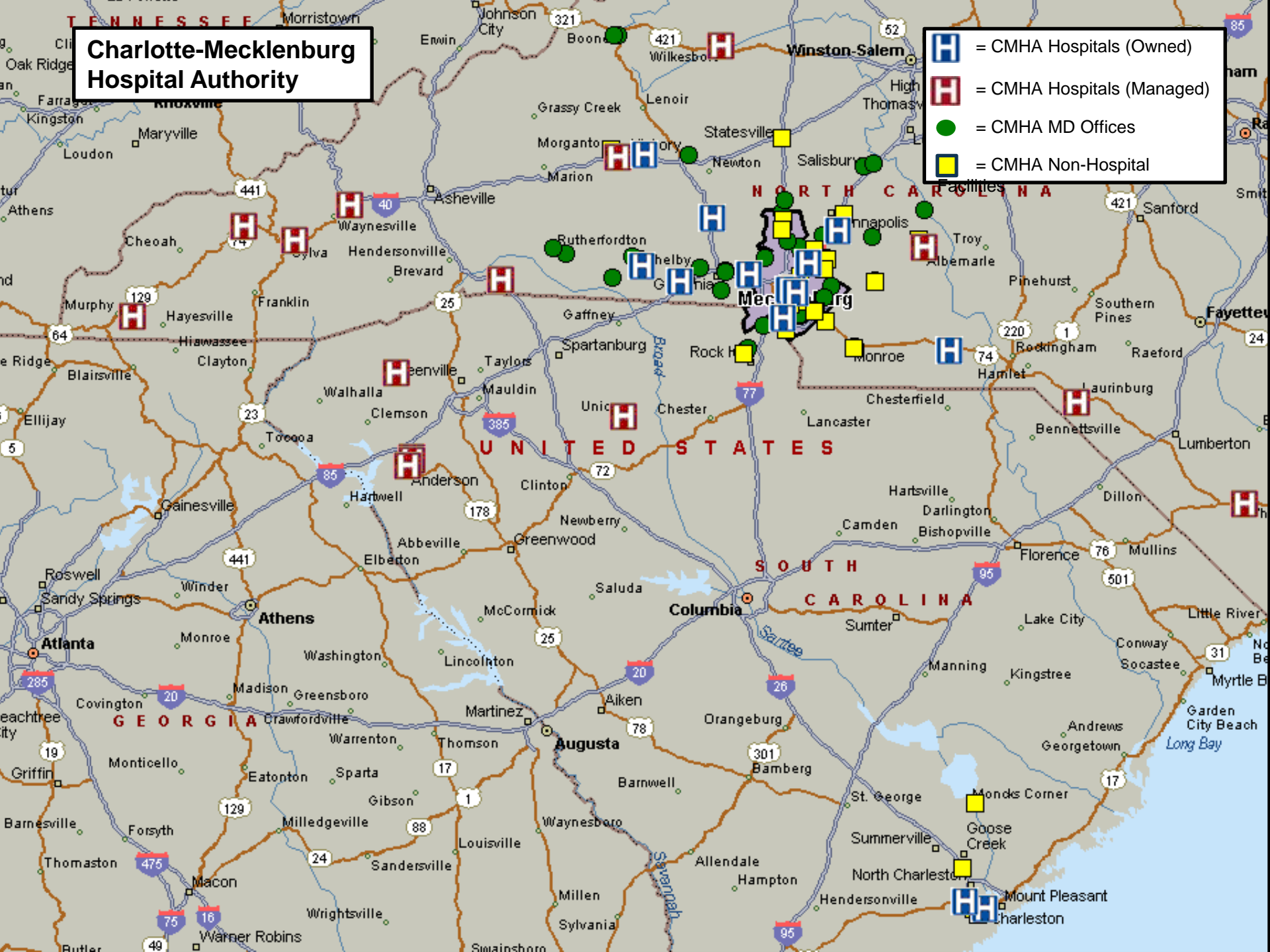
1970s versus 2011

The changing landscape of healthcare

Growth of multi-hospital systems

**Charlotte-Mecklenburg
Hospital Authority**

-  = CMHA Hospitals (Owned)
-  = CMHA Hospitals (Managed)
-  = CMHA MD Offices
-  = CMHA Non-Hospital



Reasons to Retain CON Regulation

**As of July 30, 2011, the N.C.
Medical Care Commission had
\$7,297,062,052
in financings outstanding.**

OUTSTANDING DEBT

As of June 30, 2011, the Commission has closed 406 revenue bonds, notes and leases. The total authorized principal amount of all such financings was \$17,476,806,052 and the total outstanding principal amount of all such financings as of June 30, 2011 was \$7,297,062,952 excluding financings that have been refunded. Each issue is payable solely from revenues derived from each corporate entity financed, is separately secured, and is separate and independent from all other series of bonds as to source of payment and security.

Reasons to Retain CON Regulation

**High bond ratings are affected by
CON protection for issuers.**

Some states have recently amended their certificate of need laws to reduce or remove the restrictions imposed with respect to undertaking covered activities or expenditures related to health care facilities. In each of these states there were substantial increases in the number of health care facilities such as free standing ambulatory surgery centers and imaging centers providing services in major urban areas. There have recently been some unsuccessful efforts in the North Carolina General Assembly to amend the CON Law in a similar manner. If the CON Law is so amended in the future of the Obligated Group could experience increased competition for certain health care services they currently provide, or their revenues from such services could decline, or both.

In addition, the CON Law may be amended in the future to increase or decrease the regulatory restrictions and resulting costs. For all of these reasons, the CON Law could adversely affect the revenues of the Obligated Group and may be changed in the future in ways that are adverse to the Obligated Group.

Sample Bond Book Language

Health Care providers in these states and geographic regions benefit from a combination of strong demographic and economic trends, favorable payer environments, and the presence of strong Certificate of Need regulation. Two states in particular, Virginia and North Carolina, stand out when comparing their characteristics and hospital ratings to other states in the country.

Moody's Investors Service, 2004

Reasons to Retain CON Regulation

Impact on North Carolina's Medicaid budget

Reasons to Retain CON Regulation

**Uncertainty created by federal
Affordable Care Act
("ObamaCare")**

The Affordable Care Act (ACA)'s ambiguity prevents states from making a clear and informed choice, requiring North Carolina and Minnesota to subject themselves to unknowable and potentially crippling obligations in order to continue their participation in the Medicaid program.

Reasons to Retain CON Regulation

Protection of rural and underserved communities

- **Example: Proposed relocation of Davie County Hospital from Mocksville to Bermuda Run**

In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped person, and other underserved groups and the elderly to obtain needed health care.

N.C.G.S. 131E-183(a) (3a)

Opportunities for CON law reform

**Reduce delays in provision of
needed facilities and services.**

CON Application Filing Timeline



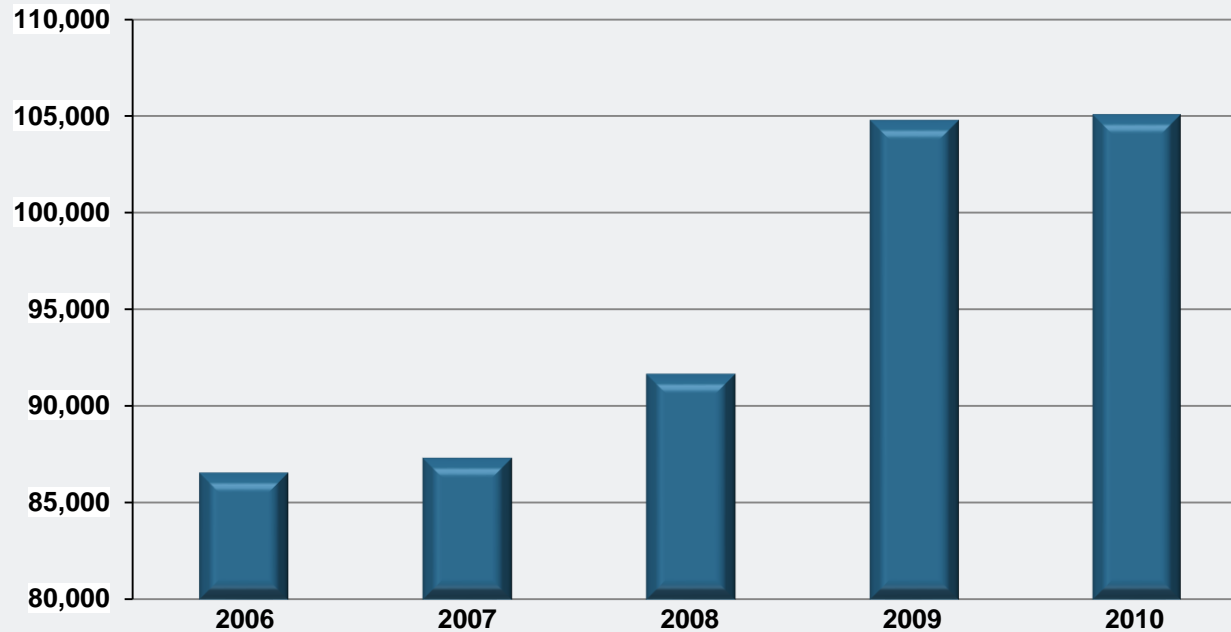
Example: Gaston Memorial Hospital

Mount Holly Emergency Room Expansion

- **Proposed in 2008**
- **Argued in Court of Appeals, Sept. 2011**

Emergency Room Visits

Gaston Memorial Hospital



Visits/Year	Year
86,549	2006
87,317	2007
91,661	2008
104,776	2009
105,081	2010

Opportunities for CON Law Reform

Impossible to estimate lost revenues, jobs, higher construction costs resulting from delays, not to mention delay in needed services.

Bond requirement inadequate to deter frivolous appeals.

Opportunities for CON Law Reform

Eliminate outdated, unenforceable requirements.

"Diagnostic Center" means a freestanding facility, program or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars (\$10,000) or more exceeds five hundred thousand dollars (\$500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars (\$500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

N.C.G.S. 131E-176 (7a)

Opportunities for CON Law Reform

Make all applicants subject to the same requirements.

The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

N.C.G.S. 131E-183 (b)

Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:

- 1. Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or**
- 2. Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or**
- 3. Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.**

Policy AC-3, State Medical Facilities Plan

What reforms should be considered?

Make all applicants subject to the same requirements

- ❖ **UNC, NC Baptist Hospitals, Duke University Medical Center, Pitt County Memorial Hospital**

AMC Operating Performance & Metrics

With the exception of NCBH, all systems show strong three year growth in operating revenue, operating cash flow and operating income

Duke and UNC show particularly strong operating results and ratios when compared to respective Moody's medians

	Mission Health System		University Health Systems of Eastern Carolina		Duke University Health System		University of North Carolina Health Care System		North Carolina Baptist Hospital & Affiliates		Carolinas Healthcare System		FY 2010 Moody's Medians*	
	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	Aa	A
Operating Revenue	\$967	7.0%	\$1,195	7.6%	\$2,150	7.8%	\$1,862	8.6%	\$971	-1.6%	\$3,855	8.5%	\$1,648	\$510
Operating Cash Flow Margin	\$109 11.2%	7.6%	\$134 11.2%	8.0%	\$332 15.5%	27.1%	\$199 10.7%	27.7%	\$102 10.5%	1.7%	\$383 9.9%	11.0%	\$173 10.8%	\$51 10.0%
Operating Income Margin	\$36 3.8%	10.9%	\$33 2.7%	2.2%	\$209 9.7%	36.8%	\$102 5.5%	61.7%	\$28 2.9%	67.3%	\$117 3.0%	62.8%	\$73 4.5%	\$14 2.6%
Net Income** Margin	\$85 8.8%	NM	\$39 3.3%	NM	\$316 14.7%	47.0%	\$157 8.4%	56.0%	\$81 8.4%	NM	\$344 8.9%	NM	\$134 8.2%	\$31 6.3%
Moody's Rating	Aa3		A1		Aa2		Aa3		Aa3		Aa3			
Cash & Investments***	\$711	8.2%	\$529	9.2%	\$1,852	7.7%	\$976	-0.2%	\$730	1.2%	\$2,553	7.5%	\$1,044	\$252
Long Term Debt	\$393	7.1%	\$529	2.2%	\$844	22.1%	\$413	2.8%	\$347	0.6%	\$1,609	-1.1%	\$553	\$194
Debt to Cash Flow	2.8x		4.8x		2.1x		1.7x		2.4x		2.9x		2.4x	3.3x
Debt to Cap	29.1%		46.1%		35.8%		21.7%		30.6%		34.0%		31.1%	38.6%

Note: Shaded area denotes margin/ratio is desirable in comparison to respective Moody's median

*Moody's median financial data based on audited financial statements of freestanding hospitals and single state systems as of 7/29/2011

**For comparability, unrealized gains/losses on investments is included in net income for all healthcare systems profiled for all years. Interest expense is also included as an operating expense

***Cash & Investments include: cash & equivalents, short-term & long-term investments and short-term & long-term assets limited as to use

The legislation creating the (UNC Health Care) System reflects a clear legislative intent to authorize the System to act with such degree of autonomy and flexibility as may be necessary to achieve these goals within the increasingly competitive health care industry.

**North Carolina Attorney General's Opinion requested by UNC Health Care System
re: Authority to Acquire Rex Hospital, February, 2000**

Presented to House Select Committee on State Owned Assets, September 2011

Opportunities for CON Law Reform

Make decisions of the State Health Coordinating Council (SHCC) more transparent and accountable

- **All members appointed by Governor – not General Assembly**
- **In recent litigation, at least 22 of 29 members were recognized to be employed by or affiliated with providers regulated under the SMFP**

Opportunities for CON Law Reform

**SHCC's decisions not subject to
scrutiny by the Rules Review
Commission.**

Not subject to review on appeal.

The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms or home health offices that may be approved.

N.C.G.S. 131E-83(a)(1)

The correctness, adequacy, or appropriateness of criteria, plans, and standards shall not be an issue in a contested case hearing.

Opportunities for CON Law Reform

**SHCC members not subject to
State Ethics Act.**

Questions?

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